

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305, titled Medical Dispute Resolution-General, and 133.307, titled Medical Dispute Resolution of a Medical Fee Dispute, a review was conducted by the Medical Review Division regarding a medical fee dispute between the requestor and the respondent named above.

I. DISPUTE

1. a. Whether there should be additional reimbursement for CPT Code 97799-CP.
- b. The request was received on April 3, 2002.

II. EXHIBITS

1. Requestor, Exhibit 1:
 - a. TWCC 60 and Letter Requesting Dispute Resolution
 - b. HCFA's
 - c. EOB
 - d. Medical Records
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
2. Respondent, Exhibit 2:
 - a. TWCC 60 and/or Response to a Request for Dispute Resolution
 - b. HCFA's
 - c. Audit summaries/EOB
 - d. Medical Records
 - e. Any additional documentation submitted was considered, but has not been summarized because the documentation would not have affected the decision outcome.
3. Per Rule 133.307 (g) (3), the Division forwarded a copy of the requestor's 14 day response to the insurance carrier on June 20, 2002. Per Rule 133.307 (g) (4) or (5), the carrier representative signed for the copy on June 21, 2002. The response from the insurance carrier was received in the Division on July 9, 2002. Based on 133.307 (i) the insurance carrier's response is timely.
4. Notice of Medical Dispute is reflected as Exhibit #3 of the Commission's case file.

III. PARTIES' POSITIONS

1. Requestor: The requestor's representative, ____, states in the correspondence dated June 12, 2002 that... "This letter is in response to a request for information regarding the fee dispute on Mr. ____ (DOS 4/4/01-6/22/01). The carrier has paid \$100 per hour for the majority of our Chronic Pain management program. The provider does not feel that we should reduce our fee, as this reimbursement does not meet TWCC criteria. The carrier has never stated why they feel that \$125 for CARF facilities is fair and reasonable. They simply state that their reimbursement rate is according to Texas MFG, in which there is no MAR... This carrier has paid the provider \$125 per unit on two separate dates of service. We attached EOB in our Reconsideration packet demonstrating this (DOS 4/13/01 and 6/18/01). This establishes that the carrier does not consistently apply the same methodology for the no MAR procedure, therefore has no basis for the reduction of our bill. In the reconsideration request, we attached EOB from various carriers who have paid us in full for Chronic Pain Management. The CPT code, which we use for Chronic Pain Management billing, is 97799-CP and our usual and customary fee was \$180-\$185 per hour. Therefore, taking a 20% reduction for non-CARF accreditation, \$144-\$148 would be the correct amount to be reimbursed as TWCC has established this method for paying as the usual and customary reimbursement..."
2. Respondent: The respondent states in the correspondence dated June 25, 2002 that... "Per Commission Rule 133.304(i)(1), Respondent's auditing company has developed (and consistently applies) a methodology to determine fair and reasonable reimbursement amounts to ensure the similar procedures provided in similar circumstances receive similar reimbursement. All Chronic Pain Management programs receive \$125 per hour if they are CARF-accredited, and \$100 if they are not. Regardless of the Respondent's methodology, the burden remains upon the Requestor/Provider to show that the amount of reimbursement requested is fair and reasonable. The requestor has failed to meet this burden..."

IV. FINDINGS

1. Based on Commission Rule 133.307(d) (1) (2), the only dates of service eligible for review are those commencing on April 4, 2001 and extending through June 22, 2001.
2. The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT or Revenue CODE	BILLED	PAID	EOB Denial Code(s)	MARS (Maximum Allowable Reimbursement)	REFERENCE	RATIONALE:
04/04/01	97799-CP (6)	\$1,080.00	\$600.00	F	DOP - \$264.00	MFG, MGR (II)(D)(G) CPT descriptor	Requestor has submitted daily treatment notes to support the services rendered as billed. Requestor has also submitted EOB's from other insurance carriers supporting payment of \$144.00 to \$148.00 per hour; therefore, reimbursement in the amount of \$10,064.00 (amount requestor has asked for) is recommended.
04/05/01	97799-CP (6)	\$1,080.00	\$600.00	F	DOP - \$264.00		
04/06/01	97799-CP (4)	\$720.00	\$400.00	F	DOP - \$176.00		
04/09/01	97799-CP (6)	\$1,080.00	\$600.00	F	DOP - \$264.00		
04/10/01	97799-CP (6)	\$1,080.00	\$600.00	F	DOP - \$264.00		
04/11/01	97799-CP (6)	\$1,080.00	\$600.00	F	DOP - \$264.00		
04/12/01	97799-CP (6)	\$1,080.00	\$600.00	F	DOP - \$264.00		
04/13/01	97799-CP (6)	\$1,080.00	\$600.00	F	DOP - \$264.00		
04/25/01	97799-CP (6)	\$1,080.00	\$600.00	F	DOP - \$264.00		
04/26/01	97799-CP (6)	\$1,110.00	\$600.00	F	DOP - \$288.00		
04/30/01	97799-CP (4)	\$740.00	\$400.00	F	DOP - \$192.00		
05/02/01	97799-CP (6)	\$1,080.00	\$600.00	F	DOP - \$264.00		
05/04/01	97799-CP (6)	\$1,080.00	\$600.00	F	DOP - \$264.00		
05/07/01	97799-CP (6)	\$1,080.00	\$600.00	F	DOP - \$264.00		
05/08/01	97799-CP (6)	\$1,080.00	\$600.00	F	DOP - \$264.00		
05/09/01	97799-CP (6)	\$1,080.00	\$600.00	F	DOP - \$264.00		
05/10/01	97799-CP (6)	\$1,080.00	\$600.00	F	DOP - \$264.00		
05/11/01	97799-CP (5)	\$925.00	\$500.00	F	DOP - \$240.00		
05/14/01	97799-CP (6)	\$1,110.00	\$600.00	F	DOP - \$288.00		
05/15/01	97799-CP (6)	\$1,110.00	\$600.00	F	DOP - \$288.00		
05/16/01	97799-CP (6)	\$1,110.00	\$600.00	F	DOP - \$288.00		
05/17/01	97799-CP (6)	\$1,110.00	\$600.00	F	DOP - \$288.00		
05/31/01	97799-CP (6)	\$1,110.00	\$600.00	F	DOP - \$288.00		
06/01/01	97799-CP (6)	\$1,110.00	\$600.00	F	DOP - \$288.00		
06/04/01	97799-CP (6)	\$1,110.00	\$600.00	F	DOP - \$288.00		
06/05/01	97799-CP (6)	\$1,110.00	\$600.00	F	DOP - \$288.00		
06/08/01	97799-CP (6)	\$1,110.00	\$600.00	F	DOP - \$288.00		
06/11/01	97799-CP (6)	\$1,110.00	\$600.00	F	DOP - \$288.00		
06/12/01	97799-CP (6)	\$1,110.00	\$600.00	F	DOP - \$288.00		
06/13/01	97799-CP (6)	\$1,110.00	\$600.00	F	DOP - \$288.00		
06/14/01	97799-CP (6)	\$1,110.00	\$600.00	F	DOP - \$288.00		
06/15/01	97799-CP (6)	\$1,110.00	\$600.00	F	DOP - \$288.00		
06/18/01	97799-CP (6)	\$1,110.00	\$750.00	F	DOP - \$288.00		
06/19/01	97799-CP (6)	\$1,110.00	\$600.00	F	DOP - \$288.00		
06/20/01	97799-CP (6)	\$1,110.00	\$600.00	F	DOP - \$288.00		
06/21/01	97799-CP (6)	\$1,110.00	\$600.00	F	DOP - \$288.00		
06/22/01	97799-CP (6)	\$1,110.00	\$600.00	F	DOP - \$288.00		
Totals		\$39,705.00	\$21,850.00				The Requestor is entitled to reimbursement in the amount of \$10,064.00

The above Findings and Decision are hereby issued this 2nd day of January 2003.

Marguerite Foster
Medical Dispute Resolution Officer
Medical Review Division

VI. ORDER

Pursuant to Sections 402.042, 413.016, 413.031, and 413.019 the Medical Review Division hereby ORDERS the Respondent to remit \$10,064.00 plus all accrued interest due at the time of payment to the Requestor within 20 days receipt of this Order.

This Order is hereby issued this 2nd day of January 2003.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

MF/mf